



Department of Veterans Affairs		<h2 style="margin: 0;">AUTHORIZATION FOR HEARING AID REPAIRS</h2>			
TO	NAME OF VENDOR		NAME AND CLAIM NO. OF VETERAN		
MAKE OF HERING AID		MODEL		SERIAL NO.	
TYPE OF AID <input type="checkbox"/> BODY <input type="checkbox"/> OVER EAR <input type="checkbox"/> EYEGLASS <input type="checkbox"/> MODULAR <input type="checkbox"/> IN THE EAR			DATE ISSUED		UNDER WARRANTY <input type="checkbox"/> YES <input type="checkbox"/> NO
DESCRIPTION OF DEFECTS <input type="checkbox"/> DEAD <input type="checkbox"/> NOISY <input type="checkbox"/> INTERMITTENT <input type="checkbox"/> DISTORTED <input type="checkbox"/> FEEDBACK <input type="checkbox"/> WEAK <input type="checkbox"/> CASE DEFECT <input type="checkbox"/> NO CASE DEFECT <input type="checkbox"/> FURTHER REPAIR NEEDED			ITEMS FORWARDED TO VENDOR <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> TRANSMITTER <input type="checkbox"/> RECEIVER <input type="checkbox"/> AIR <input type="checkbox"/> BONE <input type="checkbox"/> CORD <input type="checkbox"/> CLOTHING CLIP <input type="checkbox"/> BATTERY HOLDER-COVER <input type="checkbox"/> TUBE CONNECTOR <input type="checkbox"/> TEMPLE <input type="checkbox"/> ACTIVE _____ <input type="checkbox"/> DUMMY _____ <input type="checkbox"/> EYEGLASS FRONTS SIZE _____ <input type="checkbox"/> TEMPLE EXT. SIZE RIGHT _____ LEFT _____ <input type="checkbox"/> EYEGLASS LENSE RIGHT _____ LEFT _____ <input type="checkbox"/> CROS MIC. RIGHT <input type="checkbox"/> CROS MIC. LEFT <input type="checkbox"/> BICROS RECEIVER RIGHT <input type="checkbox"/> BICROS RECEIVER LEFT <input type="checkbox"/> PRESENTATION CASE <input type="checkbox"/> OTHER </div> <div style="width: 45%;"> FOR DENVER DISTRIBUTION CENTER USE ONLY <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> TX <input type="checkbox"/> AR <input type="checkbox"/> BO <input type="checkbox"/> C <input type="checkbox"/> CC <input type="checkbox"/> BH-C <input type="checkbox"/> TC <input type="checkbox"/> TA _____ <input type="checkbox"/> DT _____ <input type="checkbox"/> PF <input type="checkbox"/> RX <input type="checkbox"/> IX <input type="checkbox"/> RL <input type="checkbox"/> LL <input type="checkbox"/> CMR <input type="checkbox"/> CML <input type="checkbox"/> BRR <input type="checkbox"/> BRL <input type="checkbox"/> PC </div> <div style="width: 45%;"> <input type="checkbox"/> EM <input type="checkbox"/> T <input type="checkbox"/> NTA <input type="checkbox"/> RAF <input type="checkbox"/> VTA <input type="checkbox"/> HB <input type="checkbox"/> BIN. </div> </div> <div style="border: 1px dashed black; padding: 5px; margin-top: 10px; text-align: center;"> CONTROL SETTINGS </div> </div> </div>		
REMARKS <input type="checkbox"/> DO NOT REPLACE CORD <input type="checkbox"/> PLEASE RUSH					
NOTE: Vendor is authorized to repair hearing aid listed in accordance with vendor's contract. One copy of this authorization must be returned with aid to Department of Veterans Affairs, Denver Distribution Cener (905B), P.O. Box 25166, Denver, CO 80225-0166.					
SEND INVOICE TO	NAME OF VA FACILITY		AUTHORIZED BY		DATE
	Department of Veterans Affairs Denver Distribution Center (905B) P.O. Box 25166 Denver, CO 80225-0166				INITIATED BY
					ACCEPTED BY
				RECORD POSTED BY	